SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. Louise Avenue Suite 201 ~ Sioux Falls, SD 57106-3115
(605) 362-2760 ~ FAX: 362-2768 ~ www.state.sd.us/doh/nursing

CERTIFIED NURSE AIDE REGISTRY RENEWAL APPLICATION

To renew your certificate, provide verification that you have been employed as a nurse aide for a minimum of 8 hours during the past 24 month period. Your employer/former employer will complete and sign the lower Section. Please return the completed form to SD Board of Nursing; a new certificate will be mailed to you.

THIS SECTION TO BE COMPLETED BY APPLICANT

NAME _____
FIRST MIDDLE MAIDEN LAST

CERTIFICATE #A _ _ _ _ _ _ SOCIAL SECURITY # _____ DATE OF BIRTH: _____

ADDRESS _____

CITY/STATE _____ ZIP _____

TELEPHONE _____ EMAIL _____

Have you ever been found guilty of abuse or neglect? ❒YES ❒NO
Have you ever been convicted of abusing another person? ❒YES ❒NO

If you answered YES to either question, please explain dates and circumstances on a separate piece of paper.

I have been employed as a Certified Nurse Aide within the last twenty-four months. ❒YES ❒NO

APPLICANT SIGNATURE _____ DATE _____

EMPLOYMENT VERIFICATION – THIS SECTION TO BE COMPLETED BY EMPLOYER

Dates of employment: FROM _____ TO _____
(If presently employed, use "present")

Total number of hours worked during this period: _____

I declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided on this Employment Verification is true and correct.

EMPLOYER _____

ADDRESS _____

TELEPHONE _____ EMAIL _____

_____ _____
EMPLOYER REPRESENTATIVE SIGNATURE / TITLE DATE